

**Payment Error Rate Measurement (PERM)**  
**REQUEST FOR RECORDS COVER SHEET**  
**PERM-ID: [| | PermID | |]**

Date: [| | MRReSubDate | |]

<b>Patient Name:</b> [    BeneficiaryName    ] <b>Date of Birth:</b> [    BeneficiaryDOB    ] <b>Beneficiary ID:</b> [    BeneficiaryID    ] <b>Date(s) of Service:</b> [    DOSFrom    ] - [    DOSTo    ] <b>Category 1:</b> Inpatient Hospital Services	<b>Provider Number:</b> [    ProviderID    ] <b>Provider Name:</b> [    ProviderName    ]
<b>Record Submission Due Date:</b> [    MedrecDueDate    ]	

Please indicate # of  
pages in submission:

\_\_\_\_\_ pages

**Inpatient Hospital Services: Acute Inpatient, Long-Term Acute, Acute Inpatient Rehabilitation**

Please submit all *applicable* documents from the listing below to support the claim sampled.

- **Admission History and Physical (H&P)**
- **Physician Orders and Progress Notes (*signed and dated*)**
- **Medication Administration Record (MAR)**
- **Discharge Summary**
- Admission Face Sheet/Coding Summary
- Emergency Department Record and Admission Order/Notes
- Nursing Assessment/Notes
- Consultation Reports/Notes
- Cardiovascular and Respiratory Reports
- Itemized Billing Sheet (*if required based on payment method*)
- Ambulance Services
- Dialysis Treatment Record/Notes
- Operative and Procedure Reports/Notes
- Anesthesia (*Pre- and Post-Op*) and Peri-operative Record/Notes (*with start and stop times*)
- Laboratory and Diagnostic Tests/Reports
- Labor and Delivery Record/Notes
- All Transfer Forms
- Physical Therapy: Evaluation/Re-evaluation/Notes
- Speech Language Pathology: Evaluation/Re-evaluation/Notes
- Occupational Therapy: Evaluation/Re-evaluation/Notes

***Note:** Please submit the complete medical record with signatures as appropriate for the service(s) billed for the sampled claim. The documents that are bolded are frequently required for this category and service type. Please be sure to include these with your document submission, if applicable to the sampled claim.*

**Please help ensure accurate processing by placing this page on top of the records you are submitting.**

**IMPORTANT:** This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. If you are not the intended party, please notify the sender by telephone (800-393-3068) to arrange the return or destruction of the information and all copies.